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AUTHOR Schlesinger, Stephen E.
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ABSTRACT

The establishment of liability for practice, and the granting of a limited immunity from liability, are intended to have different effects on clinical practices. Establishing a limited immunity from personal liability for clinicians may lead to less protection of the constitutional rights of patients, whereas increasing malpractice liability for clinical practices may contribute to the protection of patients' constitutional rights. Further, the statutes governing mental health practices may be effective in protecting the rights of patients because they can spell out the requirements of practice in an area where rights violations may be common. (Author/PJC)

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Malpractice and Clinical Judgments: The Mental Health Perspective

Stephen E. Schlesinger, Ph.D.

Veterans Administration Edward Hines, Jr., Hospital

The relationship between the legal and mental health professions is reflected in statutes which define mental health practices and in decisions in court cases to curb abuses of patients' rights by mental health clinicians.

The Trend of Mental Health Litigation

The important point to emphasize about recent settlements of mental health-related court cases is that they represent a clear change in emphasis concerning liability for professional practices. Earlier court decisions required defendants in one form or another to correct past transgressions with large sums of money from state treasuries. The results of other, more recent suits, however, seem to suggest a shift in settlements away from the concept of institutional liability and towards at least some measure of personal liability.

The Provision of Limited Immunity for Clinical Practice

Another trend in the legal arena may be emerging which parallels developments in other professions. Some states have made provisions in their mental health statutes to allow clinicians to practice within the accepted standards of their professions while at the same time remaining immune from liability in the discharge of their duties.

Focus of the Study

The establishment of liability for practice and the granting of a

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Author address: Psychology Service (116B1), V.A. Hospital, Hines, IL. 60141

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limited immunity from liability are intended to have different effects on clinical practices. However, the manner in which the intent of each legal development is translated into its desired effect is not clear. It is one thing for the legal system to set various regulations for practice. It is wuite another to work those regulations out in light of the realities of clinical practices. This study sought to probe the effect on their practices of the legally-defined contexts within which clinicians function.

Method

Subjects

Twenty-two post-residency psychiatrists and 30 Ph.D. - level clinical psychologists served as subjects in the study. Subjects were recruited from mental health institutions and clinics and from private practice. Characteristics of the sample are contained in Table 1.

Insert Table 1 about here

Procedure

The design of this study included data collection by three methods. First, a simulation was designed which presented subjects with case material about three patients whose violent histories varied. Second, each subject was interviewed following completion of the simulation exercise. And third an analysis was made of data on admissions to New York State Department of Mental Hygiene (NYSDMH) facilities.

Preparation of the Stimuli

Two types of stimuli were prepared for the simulation. One set of stimuli consisted of two seven-minute video-taped lectures by a female

lawyer accurately identified as the director of a local legal clinic. One, the "liability" lecture, described the emerging precedent of personal liability for mental health clinicians for the professional judgments they make. The second, or "immunity" lecture, described statutory provisions of a limited immunity from personal liability which clinicians may enjoy.

The second type of stimulus was the case material to be evaluated by subjects. Case summaries of three patients were prepared. Each included the demographic and historical information which is part of a standard psychiatric interview. Since the assessment of violence potential is central to the issue of involuntary hospitalization, both the amount of violence and the certainty with which a violent history could be presumed were varied. The summary of the violent patient contained a violent history which was clear. A second patient had a clearly non-violent history. The third summary was of a patient who had a history of violence which was ambiguous. It was suggested, but it was not clear.

Execution of the Design

Subjects were randomly assigned to the three conditions of the study. Subjects in the liability and immunity conditions viewed their respective lectures. Control condition subjects saw no lecture.

All subjects were asked to read the three case summaries and to complete a response questionnaire after each case. Subject interviews were scheduled after completion of the first phase of their participation in the study.

Concurrently with these activities, data were obtained on the numbers and types of admissions to the New York State Department of Mental Hygiene facilities from April 1969 through October 1977. Both a change in the

New York Mental Hygiene Code (in 1973) and the settlement of O'Connor v. Donaldson (in 1975) occurred during this period. Analysis of these data, therefore, would allow an evaluation of correlations among changes in mental health case law and changes in the way patients are handled by the State's mental health institutions.

Hypotheses

In general, it was hypothesized that the intent of statutory regulations and court decisions is incorporated into the clinical practices of psychologists and psychiatrists. An interaction between legal instructional set (from the lectures) and the type of patients was expected such that the clarity with which a person's violent history could be presumed would affect the degree to which subjects would recommend the person's detention.

Results

The degree to which developments in mental health case law and statutes have an impact on the practices of mental health clinicians is importantly related to the degree to which clinicians' duties involve the judgments upon which malpractice suits may be based. The interview data confirmed that violence prediction was a salient issue for subjects. Ninety-four per cent of the subjects said that they make such assessments of violence potential in their clinical practices. Such assessments and the detention decisions which may result from them have been the foci of malpractice actions in the nation's courts.

Success of the Simulation

The first important question to ask about the simulation results is whether the simulation was successful in communicating two different sets

of instructions to subjects. Responses to questionnaire items indicated that subjects understood the material the lectures intended to convey.

Effects of the Instructions

Two aspects were considered in assessing the effect of the legal instructions on subjects' judgments of the three case summaries. First, the data were examined for differences in the perceptions of the three patients' potential for violence among the three groups of subjects. Second, the data were examined for differences in dispositions recommended by each group of subjects for each patient.

Perceptions of Violence Potential

The judgments of violence potential for the three patients were influenced by a complex interaction between the legal instructions subjects received and the type of patient rated ($F(4,92)=2.48$; $p < .05$). The type of instruction had no effect on the assessment of violence potential made by the three groups about the non-violent patient. The violent patient was rated as significantly less potentially violent by liability subjects than by immunity and control subjects. Immunity subjects rated the violent patient as significantly more potentially violent than they did the ambiguous patient. Control subjects alone rated both the ambiguous and violent patients as significantly more potentially violent than they did the non-violent patient.

Disposition of Patients

Each subject also recommended some disposition for each case. None of the subjects wanted to detain the non-violent patient. The introduction of either set of instructions resulted in a significant decrease in the number of subjects who would involuntarily detain the violent patient.

The violent patient would be detained by both liability and control subjects far more often than those subjects would detain the ambiguous patient ($X^2(4)=14.5$; p .01).

The ambiguous patient would be treated differently depending on the set of instructions under which the examiner functioned. Immunity subjects recommended detention for the ambiguous patient more often than controls, but liability subjects did not differ from controls in the frequency with which they recommended detention for this patient.

These findings were supported by another set of related data. Subjects were also asked to indicate the amount of restriction which they believed was necessary for treating each patient. The violent patient would be detained with significantly greater restriction under either set of instructions than (s)he would under control conditions. The ambiguous patient would be detained with the same amount of restriction by liability and control subjects. However, immunity subjects increased the amount of restriction of the ambiguous patient, particularly as compared to the control condition. Once again, the non-violent patient would not be restricted by any subjects.

Taken together, these data suggest that the two sets of instructions had different effects on subjects' behaviors. Compared to no instructions at all, liability instructions resulted in an evaluation of lesser violence potential and a lesser propensity to detain and restrict the violent patient. The immunity set, however, led to an evaluation of lower violence potential but a greater propensity to detain and restrict the ambiguous patient.

Data from subject interviews

There is additional support from subject interviews for the notion that liability instructions may lead to more conservative judgments. Awareness of developments in case law has had some effects on clinical practices. 35%

of the total sample (or two-thirds of those clinicians who said they were aware of developments in case law) reported that such developments had an effect on their practices such that they warned patients with greater frequency of the limits of confidentiality in the clinician-patient relationship, charted their interactions with patients in more detail, or kept patients longer for evaluations.

Admissions to NYSDMH facilities

Data on admissions to NYSDMH facilities suggested that the general trend toward a decreasing number of admissions to state hospitals has not been specifically influenced by a change in New York State's Mental Hygiene Code (in 1973) or by the major malpractice court decision. The change in the statute caused a change in the methods used to involuntarily detain patients such that the newly created detention provisions were used by clinicians. However, the general trend toward fewer admissions is probably due to other factors such as a general policy toward "deinstitutionalization" of hospitalized patients and an increased use of other, community-oriented mental health resources to deal with those who require treatment, but not necessarily hospitalization.

Discussion

The effect of different legal instructions

The results of this study indicate several things about the way the two types of developments in mental health case law and statutes -- the threat of malpractice and the granting of immunity -- affect the practices of clinicians. If the threat of malpractice suits has an effect, it is a complicated one. First, if one compares each instructional condition of the simulation with the control condition in which no instructions were given, the data suggest that both liability and immunity conditions have some effect on clinical practices. The threat of liability reduced the evaluations of potential

violence of the two potentially violent patients. Immunity instructions seem to have encouraged judgments of violence potential which differed according to the degree to which histories of violence could be assumed from the case summaries. Immunity instructions allowed a lesser rating of potential violence for the patient for whom a history of violence was not clear and essentially the same ratings as controls for the patient who clearly had been violent in the past.

Second, compared to controls, both the threat of liability and the granting of immunity resulted in a decrease in the frequency with which subjects in general would detain the violent patient. However, again compared to controls, the granting of immunity resulted in an increased incidence of recommendations for detention of the ambiguous patient, even though these same subjects had decreased their evaluations of the patient's potential for violence from the level of controls.

Third, it seems that providing immunity allowed subjects to make recommendations about detention which were inconsistent with their judgments of the patients' potentials for violence. This finding suggests that granting immunity may lead to clinical decisions which do not conform to statutory provisions and court decisions regarding involuntary detention of patients.

An overall view suggests that the threat of liability may lead to a greater net decrease in predictions of violence than does the granting of immunity to clinicians. Therefore, it can be expected that the threat of liability may do more than the granting of immunity to reduce the high rate of overprediction of violence which research has shown to exist.

The effect of changes in the New York Mental Hygiene Code

The examination of admission data for NYSDMH facilities demonstrated that changes in the state's Mental Hygiene Code did not effect the numbers of patients whom clinicians believed required involuntary detention. The number

of involuntarily detained patients remained essentially unchanged. For this reason, one might conclude that O'Connor v. Donaldson (1975), the Supreme Court ruling which specified that people must be judged to be dangerous before they can be detained involuntarily, had no appreciable effect on those practices of mental health professionals which the Court found violative of patients' rights. But the method by which New York State practitioners detained patients did change. Even though actual implementation of the statute's provisions may vary from judicial district to judicial district within the state (see Gupta, 1971), this change may mean two things. First, the change may mean that, overall, patients' rights are better protected than they were before the statute changed because the new procedures for involuntary detention require more frequent review of cases. Second, it may be that the statutory changes had a more direct impact on the protection of patients' rights than court decisions have had. Ultimately, patients' rights may be better protected through legislative actions than through the actions of courts.

Conclusion

The data from this study suggest that the legal system in general has an impact on clinical practices when it becomes involved in those practices. Establishing a limited immunity from personal liabolity for clinicians, as several states have done, may lead to less protection of patients' constitutional rights. This may follow from an increased willingness by clinicians to take actions with more profound constitutional implications when they believe that they are immune from liability than when they believe they can be held personally liable for the consequences of those actions.

The effect of increasing malpractice liability for clinical practices may contribute to the protection of patients' constitutional rights, as it is intended to do. Further, the study suggests that statutes governing mental health practices

may be effective in protecting the constitutional rights of patients because they can spell out clearly the requirements of practice in an area where rights violations may be common.

References

O'Connor v. Donaldson, 95 S. Ct. 2486 (1975).

Table 1

Characteristics of the Sample

	Total Sample	Psychologists	Psychiatrists
Sex			
Male	43	25	18
Female	9	5	4
Conditions			
Liability	18	11	7
Immunity	16	10	6
Control	18	9	9
Culture of Training			
United States	42	30	12
Foreign	10	0	10
Setting of Practice			
Hospital	22	11	11
Outpatient Clinic	18	15	3
Private Practice	12	8	4
Mean Age	42.5	39.5	46.7
Mean Number of Years of Practice	12.6	10.1	15.9
Median Number of Years of Practice	10.5	9.5	11.5
Mean Percentage Time in Private Practice	25.8	17.0	38.1